DCH/MMP-500 (Rev. 6/09)

Michigan Department of Community Health
Michigan Medical Marihuana Registry
P.O. Box 30083
Lansing, MI 48909
www.michigan.gov/mmp

Instructions for Applying for a Medical Marihuana Registry Identification Card

To be eligible for the Michigan Medical Marihuana Registry, you must complete the application packet and submit the following information:

☐ **APPLICATION FORM FOR REGISTRY IDENTIFICATION CARD**

- REQUIRED: Complete **Section A: APPLICANT/PATIENT INFORMATION**
- REQUIRED: Complete **Section B: PRIMARY CAREGIVER** if you are designating a caregiver
  - "Primary caregiver" means a person who is at least 21 years old and who has agreed to assist with a patient's medical use of marihuana and who has never been convicted of a felony involving illegal drugs
- REQUIRED: Complete **Section C: PERSON ALLOWED TO POSSESS PATIENT'S MARIHUANA PLANTS**
- REQUIRED: Complete **Section D: CERTIFYING PHYSICIAN INFORMATION**
- REQUIRED: **Section E: ATTESTATION, SIGNATURE, & DATE**
  - The Patient must sign and date the application

☐ **PHYSICIAN CERTIFICATION FROM MICHIGAN LICENSED MD/DO**

- Your physician must complete and sign the Physician Certification form. This must be submitted with your application. DO NOT send or have medical records sent to the registry program.

☐ **CAREGIVER ATTESTATION (IF APPLICABLE)**

☐ **COPY OF CAREGIVER'S PHOTO IDENTIFICATION (IF APPLICABLE)**

☐ **COPY OF PATIENT'S PHOTO IDENTIFICATION**

☐ **$100.00 APPLICATION FEE or $25.00 REDUCED FEE if currently enrolled in Medicaid or receiving SSI or SSD**

- **Make check or money order payable to "State of Michigan—MMMP"**

☐ **COPY OF DOCUMENTATION VERIFYING RECEIPT OF BENEFITS, IF SUBMITTING REDUCED FEE**

- **For example: Award Letter, MI Health Card, most recent SSA-1099, etc.**

☐ **RETAIN A COPY OF YOUR APPLICATION FOR YOUR FILES**

- These are proof that your application is in process.

☐ **SEND ALL REQUIRED DOCUMENTS <u>TOGETHER IN ONE</u> FILING TO:**

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- Do not send any documentation separately from the application.
- Your application will be approved or denied within 15 days of receipt by the department.
  - If approved, your card will be issued and sent to the mailing address provided.
  - If determined incomplete, your application will be denied. You can then resubmit a copy of your application with all required documents for reconsideration without an additional fee (unless you were denied for an insufficient fee) for up to one year from receipt of your first application.
- If the information provided on the application is determined to be false at any time, your registration card will become null and void.
- The patient and primary caregiver, if applicable, will each receive a registry ID card.
- Forms are available at http://www.michigan.gov/mmp.

If you have questions, contact the Michigan Medical Marihuana Registry Program at (517) 373-0395.

DCH/MMP-010 (Rev. 6/09)

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FOR OFFICIAL USE ONLY

APPLICATION FORM FOR REGISTRY IDENTIFICATION CARD

INSTRUCTIONS: Please complete all required information to comply with the registration requirements of the Michigan Medical Marihuana Registry. Attach readable copies of photo ID(s) and your registration fee. **The registration fee for this application is $100.00 or $25.00 if the patient is enrolled in Medicaid or receiving SSI or SSD (copies of qualifying documentation must be attached). Enclose your check or money order made payable to *State of Michigan—MMMP*. We do not accept Credit or Debit Cards.**

PLEASE TYPE OR PRINT LEGIBLY

Section A: APPLICANT/PATIENT INFORMATION: *(REQUIRED)*

NAME (First, M.I., Last) ☐ Male ☐ Female

SOCIAL SECURITY NUMBER - -

DATE OF BIRTH / /

MAILING ADDRESS

PHONE NUMBER ( )

CITY | **STATE** MI | **ZIP CODE** | **ALTERNATE PHONE NUMBER**

Photo Identification: A clear photocopy of one of the following must be attached. Please check appropriate box:

☐ **MI Driver's License or MI ID Card #**_____ ☐ **Other**_____

Section B: PRIMARY CAREGIVER: *(IF APPLICABLE)*

NAME (First, M.I., Last) ☐ Male ☐ Female

SOCIAL SECURITY NUMBER - -

DATE OF BIRTH / /

MAILING ADDRESS

TELEPHONE NUMBER ( )

CITY | **STATE** MI | **ZIP CODE** | **ALTERNATE PHONE NUMBER**

Photo Identification: A clear photocopy of one of the following must be attached. Please check appropriate box:

☐ **MI Driver's License or MI ID Card #**_____ ☐ **Other**_____

Section C: PERSON ALLOWED TO POSSESS PATIENT'S MARIHUANA PLANTS: *(REQUIRED)*

SELECT ONE: ☐ **APPLICANT/PATIENT** ☐ **PRIMARY CAREGIVER (Caregiver Attestation & photo ID is required)**

Section D: CERTIFYING PHYSICIAN INFORMATION: *(REQUIRED)*

PHYSICIAN'S NAME | **MAILING ADDRESS** | **TELEPHONE NUMBER** ( )

Section E: ATTESTATION, SIGNATURE, & DATE: *(REQUIRED)*

I understand that according to the Michigan Medical Marihuana Act, the department shall verify to law enforcement personnel whether my registry ID card is valid using my registration number only.

☐ **By checking this box, I additionally authorize the release of my name and date of birth to law enforcement, to confirm identity, only if law enforcement has provided the Michigan Medical Marihuana Program with my valid registration number**

By signing below, I attest that the information I have entered on this application is true and accurate:

_____ _____

Signature of Applicant/Patient **Date**

DCH/MMP-020 (Rev. 6/09)

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Physician Certification

INSTRUCTIONS: THIS CERTIFICATION IS TO BE COMPLETED IN ITS ENTIRETY BY THE PHYSICIAN. Please complete **all** of the information required on this form. Sign the form and keep a copy in the patient's medical record. **The patient must submit this certification along with his/her application for a Michigan Medical Marihuana Registry identification card.** This does not constitute a prescription for marihuana. You may contact the Michigan Medical Marihuana Program at (517) 373-0395 if you have any questions or concerns.

PLEASE TYPE OR PRINT LEGIBLY

PATIENT INFORMATION: *(REQUIRED)*

Name (First, M.I., Last) **DATE OF BIRTH** / /

PHYSICIAN INFORMATION: *(REQUIRED)*

Name (First, M.I., Last) **SELECT ONE:** ☐ **M.D.** ☐ **D.O.**

MAILING ADDRESS **MI LICENSE NUMBER**

CITY **STATE** **ZIP CODE** **TELEPHONE NUMBER** ( )

PHYSICIAN'S STATEMENT: *(REQUIRED)*

The above-named patient has been diagnosed with and is currently undergoing treatment for the following debilitating medical condition (check appropriate boxes):

- ☐ Cancer
- ☐ Glaucoma
- ☐ HIV or AIDS Positive
- ☐ Hepatitis C
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Crohn's Disease
- ☐ Agitation of Alzheimer's Disease
- ☐ Nail Patella

OR a medical condition or treatment that produces, for this patient, one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of medical marihuana.

- ☐ Cachexia or Wasting Syndrome
- ☐ Severe and Chronic Pain
- ☐ Severe Nausea
- ☐ Seizures (Including but not limited to those characteristic of Epilepsy.)
- ☐ Severe and Persistent Muscle Spasms (Including but not limited to those characteristic of Multiple Sclerosis.)

Comments: (Please Type or Print Legibly)

CERTIFICATION, SIGNATURE, & DATE: *(REQUIRED)*

I hereby certify that I am a physician licensed to practice medicine in Michigan. I have responsibility for the care and treatment for the above-named patient. It is my professional opinion that the applicant has been diagnosed with a debilitating medical condition as indicated above. The medical use of marihuana is likely to be palliative or provide therapeutic benefits for the symptoms or effects of applicant's condition. This is not a prescription for the use of medical marihuana. Additionally, if the patient ceases to suffer from the above identified debilitating condition, I hereby certify I will notify the department in writing.

Physician's Signature **Date**

Provide the name and telephone number of contact person to verify validity of certification:

( )

(Name – Please Print) **(Telephone Number)**

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Caregiver Attestation

INSTRUCTIONS: Please complete all required information in order to comply with the requirements of the Michigan Medical Marihuana Registry.

PLEASE TYPE OR PRINT LEGIBLY

DECLARATION: *(REQUIRED)*

I, _____, do hereby declare:
CAREGIVER'S NAME (PRINTED)

that I am willing and able to serve as the primary caregiver for:

_____
PATIENT'S NAME (PRINTED)

I further certify that:

- I am at least 21 years of age
- I have never been convicted of a felony offense involving illegal drugs
- I understand that my caregiver registration will become null and void if I am convicted of a felony offense involving illegal drugs
- I am a caregiver for no more than 5 patients
- I have submitted a copy of my photo ID to my qualifying patient to submit with this application

SOCIAL SECURITY NUMBER & DATE OF BIRTH: *(REQUIRED)*

SOCIAL SECURITY NUMBER	DATE OF BIRTH
- -	/ /

PRIMARY CAREGIVER INFORMATION: *(REQUIRED)*

MAILING ADDRESS			TELEPHONE NUMBER
			( )
CITY	**STATE**	**ZIP CODE**	**ALTERNATE PHONE NUMBER**
	MI		( )

OTHER NAMES USED: *(REQUIRED, IF APPLICABLE)* Attach a separate page if more space required

(First, M.I., Last)

(First, M.I., Last)

(First, M.I., Last)

I understand that it is necessary to secure a criminal conviction history as part of the screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial recordkeeping organization to verify if I have been convicted of any felony offenses involving illegal drugs. The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my registration and that such misrepresentation is punishable by law.

_____ _____
Signature of Primary Caregiver **Date**